MEDICAL MUTUAL®

Mutual News

First Quarter, 2021

Stay Informed with the Provider Manual

The Provider Manual is available at MedMutual.com/Provider > Provider Manual. It is updated quarterly to include the latest policies, procedures and guidelines providers need to work effectively with Medical Mutual.

Sub-sections Revised — Current updates to the Provider Manual include:

- Section 2 – Claims Overview
  - Completing the CMS-1500 Claim Form
- Section 3 – Clinical Quality and Health Services Overview
  - Clinical Practice Guidelines
  - Continuity of Care Guidelines

Contact Us

Effective Apr. 1, 2021, the phone number for our Medical Mutual Provider Contracting team is now 1-800-625-2583. This number is being used in all of our provider contracting regions.

If you do not know who your Provider Contracting Representative is, you can find the information on the contract us page of MedMutual.com/Provider.

General Information

Notice of Changes to Prior Authorization Requirements: Electronic Prior Authorization Requirement for Private Duty Nursing Services

Effective June 1, 2021, Medical Mutual will require all Private Duty Nursing prior authorization (PA) requests from providers to be submitted through NaviNet at navinet.force.com. After this date, we will no longer accept Private Duty Nursing PA requests via fax or phone.

With NaviNet you can:

- Receive instant confirmation that your request was submitted
- Access real-time status updates including outcome determination
- Upload supporting documentation in PDF format
- Provide discharge planning information and discharge date notification

You can start submitting Private Duty Nursing PA requests immediately through NaviNet, and can access the user guide on the Plan Central page in NaviNet.

Already Registered on NaviNet?

If your facility is already registered on NaviNet, you can request to add Medical Mutual access by following the steps provided at support.nanthealth.com/health-plans/navinet-basics/user-guide/adding-health-plan-your-office.

Register Today!

If your facility is NOT registered on NaviNet, you can register for free by visiting the NaviNet website at navinet.secure.force.com.

After June 1, 2021, no phone or fax PA requests will be accepted, so please allow one week for NaviNet registration and security.

For additional information, contact the NaviNet service department Monday through Friday from 8:00 a.m.-5:30 p.m. EST at 1-888-482-8057. After hours, please leave a voicemail and your call will be returned the following business day.

You can also contact your Medical Mutual Provider Contracting Representative at 1-800-625-2583. If you do not know who your Provider Contracting Representative is, you can find out on the Contract Us page of MedMutual.com/Provider.

Correctly Converting National Drug Codes for Medical Claims

Drug products are assigned a unique 10-digit, 3-segment number by the U.S. Food & Drug Administration (FDA). This number, known as the National Drug Code (NDC), identifies the labeler, product and trade package size. The NDC will be in one of the following configurations: 4-4-2, 5-3-2, or 5-4-1.

Medical claims, however, require the NDC to be converted to an 11-digit number in a 5-4-2 format. The hyphens indicated below are used solely to illustrate the various formatting examples for the NDC. Do not use hyphens when entering the actual data on your claim.

Converting NDCs from 10-digits to 11-digits (NDC 5-4-2 format):

10-Digit Configuration	Actual 10-Digit Example	11-Digit Conversion Example
4-4-2	0002-7597-01	00002-7597-01
5-3-2	50242-040-62	50242-0040-62
5-4-1	60575-4112-1	60575-4112-01

The most frequent NDC error we see is the failure to accurately convert the code into the 11-digit 5-4-2 format. This is primarily caused by incorrectly adding a zero (0) to the beginning of a 5-3-2 or 5-4-1 NDC configuration. Many programs will pad the product code or package code segments of the NDC with a leading zero instead of an asterisk, which may contribute to an inaccurate NDC being reported on a medical claim.

It is important to pay close attention to your medical claims to ensure that the NDCs used are converted correctly to the 5-4-2 format.

For more information on NDCs, go to www.fda.gov/drugs/development-approval-process-drugs/national-drug-code-database-background-information.
The NDC 5-4-2 format is available from the FDA Federal Drug Listing Branch HFN-315, 5600 Fishers Lane, Rockville, MD 20857.

COVID-19 Vaccine Information

In response to the recent U.S. Food and Drug Administration (FDA) emergency use authorizations of COVID-19 vaccines, Medical Mutual has made available a COVID-19 Vaccine Provider FAQ document at MedMutual.com/Provider. The FAQ document will be updated regularly as more information becomes available.

Reminder to Enroll to Receive Electronic Communications with Availity

Medical Mutual transitioned our provider portal to Availity, a multi-payer platform, to provide you with a more comprehensive experience and easier access to information.

To receive electronic communications, please take the following actions:

- **Enroll or login** to Availity at Availity.com/medicalmutual.
- **Choose e-communications.** Locate the Medical Mutual payer space, go to the Applications Tab and input the applicable email address.
- **Enjoy the benefits** of e-communications vs. paper including:
  - Faster and more timely communication of essential information
  - Easier sharing and referencing of previous communications
  - Convenient access to additional information/resources through links within the e-communication

If you have any questions, please contact your Medical Mutual Provider Contracting Representative. If you don't know who your Provider Contracting Representative is, please visit the Contact Us page at MedMutual.com/Provider.

Change to Medical Mutual Provider Contracting Phone Number

Effective Apr. 1, 2021, the phone number for our Medical Mutual Provider Contracting team changed to 1-800-625-2583. This number will be used in all provider contracting regions.

If you have any questions, please contact your Medical Mutual Provider Contracting Representative. If you do not know who your Provider Contracting Representative is, you can find the information on the contract us page of MedMutual.com/Provider.

Weekend Coverage for Post-Acute Care (PAC) Admission Authorizations

Effective Apr. 3, 2021, Medical Mutual's clinical staff will be available to receive and process weekend authorization requests for members requiring admission to Inpatient Rehabilitation and Skilled Nursing Facilities.

Weekend Coverage

New Availability:	Saturdays and Sundays
Hours:	10:00 AM – 2:00 PM
Telephone Number:	1-800-833-8505

Weekend PAC Authorization Process

1. Hospital personnel may request a weekend PAC admission approval by calling 1-800-833-8505.
2. Medical Mutual clinical staff will acknowledge receipt of your request within an hour during our weekend coverage hours.
3. Hospital personnel must provide the clinical information listed on the Acute Discharge Planning Worksheet to facilitate admission review. This worksheet is available on our provider website at www.medmutual.com/For-Providers/Resources/Forms.aspx
4. Physician Peer-to-Peer will be scheduled per our normal scheduling guidelines.

These changes are intended to ensure that members who are discharged on Saturdays and Sundays can transition to the next level of care without delay. Authorizations for member transfers provided during the week are valid for 4 days from the authorization date to help facilitate weekend transfers.

If you have any questions, please contact Robin Bender at 1-855-225-7626.

Medical Policy Updates

Medical Policy Updates

The Corporate Medical Policies (CMPs) developed, revised or retired between Oct. 1, 2020, and Dec. 31, 2020, are outlined in the following charts. CMPs are regularly reviewed, updated, added or withdrawn, and are subject to change. For a complete list of CMPs, please visit MedMutual.com/Provider and select Policies and Standards > Corporate Medical Policies.

CMP Name	Revised, New or Retired
Abraxane	Revised
Actemra_IV	Revised
Adcetris	Revised
Aliqopa	Revised
Aranesp	Revised
Asparlas	Revised
Bavencio	Revised
Beovu	Revised
Berinert	Revised
Besponsa	Revised
Bevacizumab	Revised
Botox	Revised
Cinqair	Revised
Copaxone & Glatopa	Revised
Darzalex	Revised
Dupixent	Revised
Epoetin	Revised
Erbitux	Revised
Erwinaze	Revised
Eylea	Revised
Fasenra	Revised
Firazyr	Revised
General Oncology PA	Revised
Global PA	Revised
Growth Hormone	Revised
Haegarda	Revised
Hemlibra	Revised
Ilaris	Revised

CMP Name	Revised, New or Retired
Imfinzi	Revised
Infliximab	Revised
Interferon Beta	Revised
IVIG	Revised
Kadcyla	Revised
Kalbitor	Revised
Keytruda	Revised
Krystexxa	Revised
Kymriah	Revised
Kyprolis	Revised
Lemtrada	Revised
Levoleucovorin	New
Lucentis	Revised
Lumoxiti	Revised
Macugen	Revised
Mircera	Revised
Monjuvi	Revised
Mylotarg	Revised
Nucala	Revised
Oncaspar	Revised
Opdivo	Revised
Orencia IV	Revised
Pemetrexed	Revised
Perjeta	Revised
Polivy	Revised
Poteligeo	Revised
Praluent	Revised
Reblozyl	Revised
Remodulin	Revised
Repatha	Revised
Rituximab_IV	Revised
SCIG	Revised
Simponi ARIA	Revised
Soliris	Revised
Spravato	Revised
Stelara	Revised

CMP Name	Revised, New or Retired
Synagis	Revised
Tecentriq	Revised
Tegsedi	Revised
Testosterone Injectables	Revised
Trastuzumab IV	Revised
Uplizna	Revised
Hyaluronic Acid Derivatives	Revised
Visudyne	New
Xolair	Update
Yervoy	Update
Yescarta	Update
Yondelis	Update
Zilretta	Update

For a list of services requiring prior approval or considered investigational, please visit MedMutual.com/Provider and select Policies and Standards > Prior Approval & Investigational Services.

Pharmacy

Pharmacy Prior Approval Requirements

Medical Mutual requires prior approval for the following drugs regardless of whether they are covered under the medical or pharmacy benefits:

- All new specialty drugs
- All new drugs with significant safety, clinical or potential abuse or diversion concerns

This requirement is intended to ensure medications are used safely and will be effective for members. The prior approval criteria for these drugs are detailed in the Global PA/New Drug Prior Approval policy available at Medmutual.com/Provider on the following pages:

For drugs covered under the medical benefit: Select Policies and Standards > Corporate Medical Policies. This page also includes all current Corporate Medical Policies and information about our prior approval services and Magellan Rx's secure provider portal, a web-based tool at www1.magellanrx.com that providers can use to manage prior approval requests for medications.

For drugs covered under the pharmacy benefit: Select Policies and Standards > Prescription Drug Resources, then click the link under Prior Authorization to see the list. This page also includes information about our other coverage management programs (e.g., step therapy, quantity limits) and formularies, as well as a link to the ExpressPAth tool.

Update to Medical Benefit Product Coverage for Medical Mutual Commercial and Affordable Care Act (ACA) Plans

As we announced on the In The News page of our MedMutual.com/Provider website on January 26, 2021, in order to support our provider community through additional access to more biosimilars, Medical Mutual updated the preferred trastuzumab products list to include all available trastuzumab biosimilars effective February 4, 2021. Members who are on existing therapy will be required to try the preferred drug at the time of prior approval renewal. For members new to the therapy, Medical Mutual will require a trial of the preferred drugs before a non-preferred drug can be prescribed. If the provider believes that a member has already satisfied the step therapy requirement or a non-preferred drug is medically necessary, the provider should follow the Medical Mutual of Ohio coverage determination process to request the non-preferred drug.

The preferred and non-preferred trastuzumab products for Medical Mutual commercial and ACA plans are noted in the following chart. To view the list of drugs that require step therapy effective January 1, 2021, go to www.medmutual.com/-/media/MedMutual/Files/Providers/In-the-News/2020/111920_Commercial-and-ACA-Medical-Benefit-Product-Coverage-for-Medical-Mutual-Plans_FINAL.pdf

Preferred Drugs	Non-Preferred Drug
Herzuma (Q5113) or Kanjinti (Q5117) or Ogivri (Q5114) or Ontruzant (Q5112) or Trazimera (Q5116) New preferred products effective February 4, 2021	Herceptin (J9355)
Herzuma (Q5113) or Kanjinti (Q5117) or Ogivri (Q5114) or Ontruzant (Q5112) or Trazimera (Q5116) New preferred products effective February 4, 2021	Herceptin Hylecta (J9356)

*Preferred products are subject to any benefit limitation set forth in a member's benefit certificate.

For more information, please visit Medmutual.com/For-Providers, Policies and Standards, Corporate Medical Policies.

Incorporating Antibiotic Stewardship in Your Practice

The impact of antibiotic resistance is growing. There are more than 2.8 million antibiotic-resistant infections occurring in the US each year, resulting in more than 35,000 deaths. The Centers for Disease Control and Prevention (CDC) also estimates approximately 47 million courses of antibiotics are prescribed unnecessarily each year.

Two important measures monitored by the National Committee for Quality Assurance (NCQA) related to antibiotic use are:

- Appropriate Treatment for Upper Respiratory Infections (URI)
- Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)

Antibiotic stewardship, the effort to measure and improve how antibiotics are prescribed, can help you stay diligent and ensure appropriate antibiotic use with your patients. Here are some guidelines for incorporating antibiotic stewardship.

1. Design and implement practices to reduce antibiotic resistance
   a. Recommend watchful waiting practices (when appropriate)
   b. Recommend symptom relief that can be obtained over-the-counter
2. Monitor your antibiotic prescribing practices
   a. Evaluate prescribing habits
   b. Participate in continuing education courses
   c. Track quality improvements
3. Educate patients about antibiotic stewardship
   a. Educate patients about virus vs. bacteria and how each respond to treatment options
   b. Help patients understand the practices you've implemented to prevent antibiotic resistance for their health and the health of the greater community

If you need help starting an antibiotic stewardship program, or are looking to assess if your current program is working, here are some tools from the CDC you can use.

- The Core Elements of Hospital Antibiotic Stewardship Programs www.cdc.gov/antibiotic-use/healthcare/pdfs/assessment-tool-P.pdf
- The Core Elements of Outpatient Antibiotic Stewardship www.cdc.gov/antibiotic-use/community/pdfs/16_268900-A_CoreElementsOutpatient_check_1_508.pdf

References and Resources

1. Antibiotics Aren't Always the Answer. Centers for Disease Control. Available at: Antibiotics Aren't Always the Answer (cdc.gov). Accessed on January 10, 2021.
2. Over Prescribing Antibiotics in a Pandemic. Pharmacy Benefit News (Issue #387). Available at: Pharmacy Benefit News | Pro Pharma Pharmaceutical Consultants, Inc.™ (propharmaconsultants.com). Accessed on January 21, 2021.
3. Antibiotic Resistance Threats In the United States 2019. Centers for Disease Control. Available at https://www.cdc.gov/drugresistance/pdf/threats-report/2019-ar-threats-report-508.pdf. Accessed January 5, 2021
4. Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB). NCQA. Available at: Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis - NCQA. Accessed January 10, 2021
5. Antibiotic Resistance Questions and Answers. Centers for Disease Control. Available at: https://www.cdc.gov/antibiotic-use/community/about/antibiotic-resistance-faqs.html. Accessed January 22, 2021.

Risk Adjustment

Upcoming Medical Records Requests for Risk Adjustment Data Validation Audit

Medical Mutual is required to participate in the annual Risk Adjustment Data Validation (RADV) audit, which is led by the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS). This audit verifies the accuracy of payments to Medical Mutual from CMS based on diagnosis data reported to CMS. Your practice may receive a request for medical records.

When preparing the medical records, please ensure they are authenticated and meet the documentation requirements established by HHS. Acceptable chart components include, but are not limited to:

- Histories and physicals
- Progress notes/office notes
- Pathology reports
- Discharge summaries

Records from telephone visits, lab results and medication orders are not considered valid documentation. For more information about coding guidance and the RADV audit, please refer to

- CMS RADV Checklist www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Downloads/radvchecklist.pdf
- 2019 HHS RADV Postponement Memo www.cms.gov/files/document/2019-HHS-RADV-Postponement-Memo.pdf

The Benefit Year 2019 RADV was postponed and is now starting with medical record requests being sent March through August 2021. HHS and CMS stated that the timeline for the Benefit Year 2020 RADV audit will begin in May 2021. This will result in overlapping medical record requests beginning in July 2021.

We appreciate your assistance and thank you for working with us to improve the health of our members. If you have questions, please contact your Medical Mutual Provider Contracting representative.

Please Note: Medical Mutual's agreements with our medical record retrieval vendors stipulate explicit criteria for working with our providers' offices in a respectful, non-disruptive and efficient manner. The agreements also ensure that any information shared by you during chart retrieval activities remains confidential in accordance with all applicable state and federal laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As you are aware, HIPAA regulations permit a covered entity, such as a physician practice, to disclose protected health information (PHI) to another covered entity, such as a health plan, without obtaining an enrollee's authorization or consent, for the purpose of facilitating healthcare operations.

None of the information included in this article is intended to be legal advice. It remains the provider's responsibility to ensure that all coding and documentation are done in accordance with applicable state and federal laws and regulations.

Earn One Free CEU with Our Customized Risk Adjustment Coding Webinar

At Medical Mutual, we strive to develop and maintain collaborative relationships with our contracted providers. To help with this goal, our Risk Adjustment Coding team is offering a coding webinar tailored to your practice. This webinar gives you the opportunity to earn one free continuing education unit (CEU) through the American Academy of Professional Coders (AAPC).

The webinar covers

- Items pertaining to coding and documentation guidelines for ICD-10-CM
- Examples from your specific documentation of things you have done well
- Opportunities for improvement
- Coding trends compared to your peers

Please email Katy Davis at katy.davis@medmutual.com to schedule a webinar date and time that is convenient for you.

Medicare Advantage

Advance Beneficiary Notice of Non-Coverage (ABN)

As a reminder, the Advance Beneficiary Notice of Non-Coverage (ABN) is not permitted to be used for Medicare Advantage members. While this notice may be used with original Medicare beneficiaries, it is not acceptable for use with members of Medical Mutual's Medicare Advantage plans. If a provider believes an item or service may not be covered, or could be covered only under specificc conditions, the appropriate process for the provider or the Medicare Advantage member to follow is:

- Contact Medical Mutual at the number listed on the member's identification card to confirm benefits and eligibility
- Request a prior written advance determination of coverage (also known as a prior authorization request) from Medical Mutual. This should be completed in advance of providing the service to the member and may be requested using Medical Mutual's Prior Approval Form available on our website at: Provider.MedMutual.com, Tools & Resources, Forms, Prior Approval Form

DO NOT HAVE THE MEDICARE ADVANTAGE MEMBER SIGN A WAIVER OR ANY OTHER ADVANCE NOTICE.

If the service requested by the provider is determined to be not covered, the provider and the Medicare Advantage member will receive a Notice of Denial of Medicare Coverage (NDMC). This notice will inform the Medicare Advantage member of his/her liability, which will provide documentation that the Medicare Advantage member was notified prior to the receipt of the service and that he/she is liable for the full cost of the service.

Medical Mutual expects all Medicare Advantage Network providers to follow this process.

Update to Medical Benefit Drug Coverage for Medical Mutual Medicare Advantage Plans

As we announced on the In The News page of our MedMutual.com/Provider website on January 26, 2021, in order to support our provider community through additional access to more biosimilars, Medical Mutual updated the preferred trastuzumab products list to include all available trastuzumab biosimilars effective February 4, 2021. Members who are on existing therapy will be required to try the preferred drug at the time of prior approval renewal. For members new to the therapy, Medical Mutual will require a trial of the preferred drugs before a non-preferred drug can be prescribed. If the provider believes that a member has already satisfied the step therapy requirement or a non-preferred drug is medically necessary, the provider should follow the Medical Mutual of Ohio coverage determination process to request the non-preferred drug.

The preferred trastuzumab products for Medical Mutual Medicare Advantage plans are noted on the left side of the following chart. The non-preferred drugs are shown on the right. To view the Part B Step Therapy policy and all Part B drugs that require step therapy please go to www.medmutual.com/-/media/MedMutual/Files/Providers/CorporateMedicalPolicies/201936_Medicare-Part-B-Step-Therapy.pdf

Preferred Drugs	Non-Preferred Drug
Herzuma (Q5113) or Kanjinti (Q5117) or Ogivri (Q5114) or Ontruzant (Q5112) or Trazimera (Q5116) New preferred products effective February 4, 2021	Herceptin (J9355)
Herzuma (Q5113) or Kanjinti (Q5117) or Ogivri (Q5114) or Ontruzant (Q5112) or Trazimera (Q5116) New preferred products effective February 4, 2021	Herceptin Hylecta (J9356)

*Preferred products are subject to any benefit limitation set forth in a member's benefit certificate.

For more information, please visit Medmutual.com/For-Providers, Policies and Standards, Corporate Medical Policies.

Schedule Your Medical Mutual Medicare Advantage Members for their Wellness Visits

Medical Mutual would like to remind you to schedule Medical Mutual Medicare Advantage members for their Welcome to Medicare visit or Annual Wellness visit (AWV).

Welcome to Medicare Visit

Medical Mutual's Medicare Advantage members are entitled to receive a Welcome to Medicare visit within the first 12 months of Medicare Part B coverage for a $0 copay.

Annual Wellness Visit

After a Welcome to Medicare Visit, Medicare Advantage members are entitled to receive an Annual Wellness visit every 12 months for a $0 copay. The AWV can be completed at any time during the calendar year and does not require a full year from the last service to receive the benefit.

Only the codes listed below are included in the $0 copay for wellness visits. If other services are billed with the visit, and those services are normally subject to a copay or coinsurance, that copay or coinsurance will still apply even if the primary reason was a wellness visit.

Wellness Visit Submission Codes

- You may submit the following code for the one-time Welcome to Medicare visit:
  - G0402

Only one initial visit is eligible per lifetime and is not to be considered a physical exam.

- You may submit one of the following codes for the AWV:
  - G0438 (first visit)
  - G0439 (subsequent visit)

All Medicare Advantage members are eligible for an initial AWV if they have been Medicare beneficiaries for at least 12 months. AWVs can be conducted one time per year.

If other evaluation and management services are provided in conjunction with the AWV, use CPT Modifier 25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) as appropriate.

These wellness visits should not be mistaken for a routine physical. Current CPT, HCPCS and descriptions associated with an Initial Preventive Physical Examination (IPPE) and AWV may be found in Medicare's "Medicare Preventive Services Quick Reference Information" guide at http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf.

Medical Mutual's Medicare Advantage members are also entitled to receive a routine physical exam in addition to the AWV and Welcome to Medicare visit. Please remember to contact Medical Mutual's Customer Service at 1-800-362-1279 to confirm benefits.

Note: All codes are subject to change. Please review coding prior to claims submission through the Centers for Medicare & Medicaid Services (CMS) website at cms.gov.

These recommendations are informational only. They are not intended to require a specific course of treatment or take the place of professional medical advice, diagnosis or treatment. Members should make decisions about care with their healthcare providers. Recommended treatment or services may not be covered. Eligibility and coverage depend on the member's specific benefit plan.

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